TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dallas Testing Inc

Respondent Name
Harford Underwriter's Insurance

MFDR Tracking Number
M4-15-1702-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted by the requestor.

Amount in Dispute: $627.58

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Original reimbursement issued was made in accordance with Texas Fee Guidelines and Fee Schedule."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2014	95913, 95886	$627.58	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service ins included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 906 – In accordance with clinical based coding edits. Component code of comprehensive/medicine
   - 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied submitted code 95913 with claim adjustment reason code "906 – In accordance with clinical based coding edits. Component code of comprehensive/medicine" and code 95886 as "107 - Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim." 28 Texas Administrative Code §134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;." Review National Correct Coding Initiatives finds;
    a. Procedure Code 95913 has a CCI conflict with Procedure code 95869. A modifier is not allowed
    b. Procedure Code 95886 is a Medicare add-on procedure. The primary code was not paid therefore, this add on code is not separately payable.
2. The Carrier's denials are supported. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 13, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.